STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155160	B. WING		02/14/2012		
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE			
OTONIES	DOOKE BELLAS!!	TATION OFNITES A CULTES		16TH ST			
		TATION CENTRE & SUITES	NEW C	ASTLE, IN 47362			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DIA (CIENCI)	DATE		
1 0000							
This visit was for a Recertification and		F0000					
	State Licensure						
	Ctate Liberioan	e carvey.					
	Survey dates:	February 6, 7, 8, 9, 13					
	and 14, 2012	, c					
	Facility number	r: 000080					
	Provider numb						
	AIM number: 1	100289330					
	Survey team:						
	Leslie Parrett F	RN TC					
	Sharon Lasher	RN					
	(February 7, 8,	9, 13 & 14, 2012)					
	Barbara Gray F	-					
	Angel Tomlinso						
	Census bed type	pe:					
	SNF/NF: 83						
	Total: 83						
	Census payor	type:					
	Medicare: 14						
	Medicaid: 55						
	Other: 14						
	Total: 83						
	Stage 2 sample	e: 15					
	These deficien	cies reflect state					
	_	n accordance with 410					
	IAC 16.2.						
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE		

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 03/15/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155160	A. BUILDING B. WING	00		LETED 1/2012		
STONEB		TATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 2/21/12 by Suzanne	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		

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Event ID: QZDZ11

Facility ID: 000080

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	TIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155160	A. BUILD	ING	00	COMPL 02/14/	
		100100	B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE	02/11/	20.2
NAME OF P	ROVIDER OR SUPPLIE	R		990 N 1			
	ROOKE REHABIL	ITATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIES	D.	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F0156 SS=B	483.10(b)(5) - (NOTICE OF RIC CHARGES The facility mus orally and in wri resident unders all rules and reg conduct and res the facility. The resident with the developed unde Such notificatio upon admission stay. Receipt o amendments to writing. The facility mus entitled to Medi time of admission when the reside Medicaid of the included in nurs State plan and is be charged; tho that the facility or esident may be charges for thos resident when or and services sp and (B) of this s The facility mus or at the time of during the resid available in the those services, services not con the facility's per	tinform the resident both ting in a language that the tands of his or her rights and gulations governing resident sponsibilities during the stay in a facility must also provide the enotice (if any) of the State er §1919(e)(6) of the Act. In must be made prior to or and during the resident's and facility must be acknowledged in the tinform each resident who is caid benefits, in writing, at the conto the nursing facility or, and becomes eligible for items and services that are sing facility services under the for which the resident may not see other items and services offers and for which the echarged, and the amount of see services; and inform each changes are made to the items ecified in paragraphs (5)(i)(A) section. It inform each resident before, admission, and periodically ent's stay, of services facility and of charges for including any charges for vered under Medicare or by diem rate.		IAU	DESTRUENCE!)		DATE

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Event ID: QZDZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155160	B. WIN			02/14/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8		990 N 1			
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	•	the manner of protecting under paragraph (c) of this					
	procedures for e Medicaid, includ assessment und determines the e non-exempt resc institutionalizatio community spou resources which available for pay institutionalized or her process o eligibility levels. A posting of nam telephone numb client advocacy survey and certiflicensure office, program, the pro network, and the and a statement complaint with th certification ager	the requirements and establishing eligibility for ing the right to request an eler section 1924(c) which extent of a couple's curces at the time of an and attributes to the see an equitable share of cannot be considered ement toward the cost of the spouse's medical care in his f spending down to Medicaid es, addresses, and ers of all pertinent State groups such as the State fication agency, the State the State ombudsman of the state of the sta					
	resident property	and misappropriation of yin the facility, and with the advance directives					
	The facility must requirements sp 489 of this chapt written policies a advance directiv include provisior written informatic concerning the r	ecomply with the ecified in subpart I of part ter related to maintaining and procedures regarding res. These requirements as to inform and provide on to all adult residents ight to accept or refuse cal treatment and, at the					

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Event ID: QZDZ11

Facility ID: 000080

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETI				
		155160	B. WIN	G		02/14/	2012
NAME OF P	ROVIDER OR SUPPLIEF	\ \			ADDRESS, CITY, STATE, ZIP CODE		
CTONED	DOOKE BELIABILI	TATION CENTRE & CUITEC			ACT F IN 472C2		
		TATION CENTRE & SUITES	_		ASTLE, IN 47362	1	
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	
PREFIX TAG	individual's optic directive. This in of the facility's publicatives and appropriate interesting in the facility must name, specialty, physician responsible. The facility must facility written intresidents and appropriate interesting in the facility written intresidents and appropriate interesting in the facility written intresidents and appropriate interesting in the facility written intresidents and use Medical how to receive recovered by such Based on interesting in the facility written intresidents were skilled explant review, the facility written intresidents were skilled services who met the crand beneficiary sample of 15. (Resident # 31 Findings included 1.) Review on a facility of Resident # 31 from skilled services of the facility written intresidents and appropriate includes a facility written intresidents and appropriate includes a facility written intresidents and appropriate interesting in the facility written inte	view and record flity failed to give a fation for the reason discharged from for 3 of 3 residents diteria for liability notices frappeal in a stage 2 graph 47 and # 67) de: 2/13/12 at 10:00 a.m. for discharge notice froices, provided by the frappeal to give a stage of the st	F01	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	nts y nt ed ce. r to ent e	COMPLETION DATE 03/15/2012
	your current Me services will er	ective date coverage of edicare Part A skilled ad: 12/29/11." No tion was documented.			included. The ED is responsible to ensure compliance. Notices will contain explaination of discharges from skilled	5	
			1		services.3) What measures w	III	

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Event ID: QZDZ11

Facility ID: 000080

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	OF CORRECTION OF CORRECTION 155160 IN PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(x3) DATE SURVEY COMPLETED 02/14/2012		
	PROVIDER OR SUPPLIER BROOKE REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
	2.) Review on 2/13/12 at 10:00 a.m. of Resident # 47's discharge notice from skilled services, provided by the Office Manager, and dated 1/20/12, indicated the resident was discharged due to "the effective date coverage of your current Medicare Part A skilled services will end: 1/20/12." No further explanation was documented. 3.) Review on 2/13/12 at 10:00 a.m. of Resident # 67's discharge notice from skilled services, provided by the Office Manager, and dated 10/24/11, indicated the resident was discharged due to "the effective date coverage of your current Medicare Part A skilled services will end: 10/24/11." No further explanation was documented. On 2/14/12 at 2:30 p.m. interview with Business Office Manager indicated "no, we do not give a detailed explanation on discharge notices unless they ask for one, then they are provided with one." 3.1-4(a)		be put into place or what syste changes will be made to ensur that the deficient practice does not recur: The interdisciplinary team will be in-serviced on liat notices and beneficiary appea by the ED on 3/6/12. Post test included. The ED is responsit to ensure compliance and will review notices for approriate documentation prior to forward to families. Non-compliance we result in further education including disciplinary action.4) How the corrective action(s) we be monitored to ensure the deficient practice will not recur. The social service designee we monitor all discharges from skilled services notices daily xeeks, bi-weekly x 2 months, monthly x 3 months and then quarterly for 2 quarters thereafter. Findings from the correctives will be reviewed mont and an action plan will be implemented for threshold belongoness. By what date the systemic changes will be complete: The corrective action will be completed on or before 3/15/12.	re s y polity ls ple ding yill ill c ill d CQI hly pow		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155160	B. WING		02/14/2012
	PROVIDER OR SUPPLIEI BROOKE REHABILI	TATION CENTRE & SUITES	990 N ²	ADDRESS, CITY, STATE, ZIP CODE 16TH ST ASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	A facility must in resident; consultant if known, not representative of member when the resident whithe potential for intervention; as resident's physic status (i.e., a defor psychosocial threatening concomplications); a significantly (i.e. existing form of consequences, of treatment); or discharge the respecified in §48. The facility must resident and, if kneeding in resident and assignment as a change in resident law or registrate law or registrate law or registrate in a significant in the facility must resident and assignment as a change in resident law or registrate law or registrate law or registrate law or registrate law and the facility must update the address and in the facility must update the address and i	NE/ROOM, ETC) Inmediately inform the at with the resident's physician; with the resident's legal or an interested family there is an accident involving the results in injury and has requiring physician and interested family and has requiring physician and interested family and has requiring physician and interested in the cal, mental, or psychosocial and terioration in health, mental, status in either life ditions or clinical and aneed to alter treatment, and aneed to discontinue and treatment due to adverse for to commence a new form a decision to transfer or sident from the facility as 3.12(a). It also promptly notify the known, the resident's legal or interested family member change in room or roommate apecified in §483.15(e)(2); or dent rights under Federal or ulations as specified in			
	Based on obse record review, notify the phys family of a diet	ervation, interview, and the facility failed to ician and the resident's change from regular to ft, for 1 of 15 residents	F0157	F-157 Notify of Changes1) W corrective action(s) will be accomplished for those reside found to have been affected to the deficient practice: Resident #96 physician was notified of	nts by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLE	ETED
		155160	B. WIN			02/14/2	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹		990 N 1	6TH ST		
STONEE	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	.	DATE
		nysician notification, in			the down grade in diet and ord		
	the stage 2 sar	mple of 15. (Resident			is now in place and family has been notified.2) How other		
	#96)				residents having the potential	to I	
					be affected by the		
	Findings include	le:			same deficient practice will be		
	1.) Resident #96's record was reviewed on 2/8/12 at 12:07 P.M. Diagnoses included but were not limited to Alzheimer's type dementia with behavioral disturbance and atypical psychosis.				identified and what corrective		
					action(s) will be taken: All	.	
					residents have the potential to		
					affected by the alleged deficie practice. The licensed nurses		
					be re-educated by the DNS/	VVIII	
					designee (3/6/12) on obtaining	,	
					speech therapy evaluation for		
	l atypical psychic	J515.			down grade in diet, physician		
	Desident #06le	aignificant about			notification of resident change	in	
		significant change			condition and obatin order to		
		Set assessment dated			change diet, utilization of dietary communication form, a	und	
		ted she required			family notification of change w		
	-	ncouragement, and			resident and notification of nev		
	cueing, with se	t up help only for			orders. Physician will be notifi		
	eating. She ha	ad no difficulty chewing			of residents with change in		
	or swallowing.				condition for orders. Licensed		
					nurse will fill out a dietary		
	Resident #96's	February, 2012			communication form when obtaining new diet order for da	ails,	
		ohysicians order			review and verification of orde	-	
	indicated the fo	•			place by DNS/designee. All		
	1/6/12-Regular	· ·			residents current dietary order	s	
					will be verified with tray card p	er	
	A nutrition care	e plan for Resident #96			DNS/designee and Dietary		
	indicated the fo	•			Manager to ensure appropriate	e	
		em-The resident is			and accurate. Review of all residents diets with orders by		
		risk related to a			DNS and Dietary Manager. 3)		
	1				What measures will be put into		
		ementia. She has a			place or what systemic change		
	1 ' ' '	and weight loss.			will be made to ensure that the		
		ain weight with no			deficient practice does not rec	ur:	
		gnificant weight loss			The licensed nurses will be		
	through the ne	xt review.			re-educated by the DNS/desig	nee	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLET	ΓED
		155160	A. BUII B. WIN			02/14/2	012
			р. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	16TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Approaches-Pi	rovide diet per MD			(3/6/12) on obtaining speech		
	order.				therapy evaluation for a down		
					grade in diet, physician notification of resident change	in	
	Resident #96 v	vas observed seated at			condition and obtain order to		
	the dining table	e with her peers on			change diet, utilization of dieta	arv	
		P.M. She was served			communication form, and fam		
		soft diet which included			notification of change with		
		bread and butter,			resident and notification of new		
	•				orders. Physician will be notif	ied	
	cake, and ground pork chop. Resident #96 was served thin milk				of residents with change in condition for orders. Licensec		
					nurse will fill out a dietary	1	
and water with her meal.				communication form when			
					obtaining new diet order for da	ailv	
	I	nary team note			review and verification of orde	-	
	documented by	y LPN # 8 on 2/10/12 at			place and family notification by	y	
	9:12 A.M., indi	cated the following:			DNS/designee. Speech thera		
	"IDT met to rev	view resident's weight			will be notified of all residents		
	in nutrition at ri	sk, due to weight loss.			down grade in diet for evaluat	ion	
		ewing or swallowing.			of resident. Residents with change in diet will be reviewed	,	
		gular diet with 2 pieces			weekly in NAR for	1	
	_	ach meal to enable			appropriateness of diet chang	e l	
		ke sandwiches out of			and review of speech therapy		
		t consumes bites to			recommendation. RD to reive	w	
	75% of meals				residents with diet change		
					monthly.4) How the corrective	•	
	encouragemer	it iiOIII StaII.			action(s) will be monitored to		
					ensure the deficient pactice w not recur: The CQI audit tool	I .	
		tray card indicated the			Change in Condition will be	.01	
		chanical soft diet. 2			utizied daily x 4 weeks, bi-wee	ekly	
	Pieces of bread	d. Single serve dishes.			x 2 months, and monthly x 3	-	
					months and for 3 quarters		
	An interview with the Dietary Manager on 2/13/12 at 2:39 P.M., indicated she				thereafter for any resident who		
					has a change in condition		
		iet recommendations			requiring a diet change. Findi	ngs	
		Resident #96 and			from CQI process will be reviewed monthly and an action	nn	
		a physician's order for a			plan will be implemented for	/II	
		• •			threshold below 95%.5) By w	hat	
	mechanicai so	ft diet. The Dietary					

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	OF CORRECTION IDENTIFICATION NUMBER: 155160	A. BUILDING B. WING		COMPLETED 02/14/2012		
	PROVIDER OR SUPPLIER BROOKE REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	DATE		
	Manager indicated "probably what happened was me and a nurse discussed her diet and decided to try a mechanical soft to see if her intakes would improve, but we did not follow through with the order." The Dietary Manager indicated there was no documentation regarding the mechanical soft diet change for Resident #96 or why. The Dietary Manager indicated she did not know when Resident #96's diet was changed from regular to mechanical soft. An interview with the Dietary Manager on 2/14/12 at 9:37 A.M., indicated Resident #96 did not do well with meats on a regular diet, so she, and RN #7 decided to try the mechanical soft diet as a nursing measure, to see if Resident #96's intakes would improve. The Dietary Manager indicated she did not receive a physician's order for the diet change, and she did not notify Resident #96's husband. 3.1-5(a)(3)	com will b	e the systemic changes will aplete: The corrective action be completed on or before 5/12.			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
		155160	B. WING		02/14/2012	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C	990 N	16TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES	NEW	CASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LISC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0282 SS=D	CARE PLAN The services pro facility must be p in accordance w plan of care.	QUALIFIED PERSONS/PER ovided or arranged by the provided by qualified persons ith each resident's written	50202		02/15/2012	
	Based on obserecord review, follow a physic diet and to leave out to assist in and failed to transmit order for a resireturned from the resident's reformouth sores 15 residents reorders, in the self (Resident #96 for the following includes 1.) Resident for the reviewed on 2/2 Diagnoses included 1.) Resident for the following includes 1.) Resident for the following following includes 1.) Resident following following following following includes 1.) Resident following follo	le: 96's record was 8/12 at 12:07 P.M. uded but were not eimer's type dementia	F0282	F-282 Services By Qualified Persons/Per Care Plan1) Wh corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice: Reside #96 physician was notified of down grade in diet and order in now in place and family has boutified and in agreement. Resident #20 dentures are removed after meals per physician order with documentation of any resident refusals with family notification. Resident #20 order have been reviewed and verified by licensed nurse and physician for accuracy and appropriateness.2) How other residents having the potential be affected by the same deficing paractice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The nursing staff will be re-educate by DNS/designee (3/6/12) on obatining physician orders and verification of orders, speech therapy evaluation with a diet down grade, dietary communication form, utilization of CNA assignment sheet and	ents by nt the is een t ers ied an r to ient d be eed d	

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Event ID: QZDZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				EΥ	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	COMPLETED	
		155160	B. WIN			02/14/2012		
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				6TH ST			
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362			
(V4) ID	CLIMMADY C	FATEMENT OF DEPICIENCIES	1	ID	- ,	<u> </u>	(V5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COM	(X5) IPLETION	
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
1710		ESC IDENTIFICATION (+	ind	review of contents of the CNA		MIL	
	or swallowing.				assignment sheet, utilizing BIF			
	D : 1 / //001	F 1 0040			and documenting on resident	`		
		February, 2012			refusals, and physician and far	nily		
		hysicians order			notification of residents with	, I		
	indicated the fo	ollowing:			condition change and			
	1/6/12-Regular	diet.			documentation. Physician wil			
					notified of residents with chang	je		
	A nutrition care	plan for Resident #96			in condition for orders. All resident physician orders have			
		Illowing: Problem-The			been reviewed per nursing			
		_			management. Admit/Re-admit	:		
	resident is nutritionally at risk related to a diagnosis of Dementia. She has a poor appetite and weight loss. Goal-To maintain weight with no				oders will be verified by 2			
					licensed nurses with IDT revie	<i>N</i> .		
					Speech therapy will be notified	to		
		_			evaluate residents with down			
	•	gnificant weight loss			grade in diet to ensure			
	through the nex				approriateness. Licensed nurs	se		
	Approaches-1.)				will uitlize a dietary communication form when			
	preference. 2.)	Monitor food and fluid			obtaining order to change a			
	intake. 3.) Mor	nitor weight. 4.)			residents diet. Charge			
	Nutrition at risk	as needed. 5.) Notify			nurses will give verbal report o	n		
	MD and family	of significant weight			residents identified on hot			
	changes, 6.)Pr	ovide diet per MD			charting/changes in condition t			
	,	ew labs as available.			assigned CNA and follow up w	ith		
					completion / check CNA	ant		
	Resident #96 w	vas observed seated at			has appropriate CNA assignments sheet.3) What measures will be			
		with her peers on			put into place or what systemic			
	_	P.M. She was served			changes will be made to ensur			
					that the deficient practice does			
		oft diet which included			not recur: The nursing staff wi			
		bread and butter,			be re-educated by DNS/design			
	_	nd pork chop. Staff			(3/6/12) on obtaining physiciar			
		sident #96 eating by			orders and verification of order			
	example and e	ncouragement. Until			speech therapy evaluation with adiet down grade, dietary	1 4		
	staff began ass	sisting and encouraging			communication form, utilization	n of		
	Resident #96, s	she sat and looked at			CNA assignment sheet and			
		e food around her on			review of contents of the CNA			
		' plates. After staff			assignment sheet, utilizing BIF	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155160	B. WING	ING		02/14/2	2012
		1		STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			6TH ST		
STONEB	ROOKE REHABIL	ITATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PR	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		7	ΓAG			DATE
	encouraged ar	nd prompted Resident			and documenting on reisdents		
	#96 to eat, she	e began eating and			refusals, and physician and fa	mily	
	drinking indepe	endently.			notification of residents with condition change and		
					documentation. Physician will	he	
	An interview w	ith RN #7 on 2/9/12 at			notified of residents with change		
		cated Resident #96 did			in condition for	-	
	· ·	t the food in her mouth			orders. Admit/Re-admit orders	;	
	-	ally eat good with			will be verified by 2 licensed		
		nt and prompts. RN #7			nurses with IDT review. Spec		
	_	dent #96 had to be fed			therapy will be notified to evalues residents with down grade in control of the state of the sta		
	at times, when encouragement and				to ensure appropriateness.	ilet	
					Licensed nurse will complete a	a	
	prompts didn't	WOIK.			dietary communication form w		
					obtaining new diet order for da	•	
	•	nary team note			review and verification of orde		
		y LPN # 8 on 2/10/12 at			place by DNS/designee. Char		
		cated the following:			nurses will give verbal report or residents identified on hot	on	
	"IDT met to rev	/iew resident's weight			charting/changes in condition	to	
	in nutrition at r	isk, due to weight loss.			assigned CNA and follow up w		
	No problem ch	ewing or swallowing.			completion / check CNA has		
	Receives a reg	gular diet with 2 pieces			appropriate CNA assignment		
	of bread with e	each meal to enable			sheet.4) How the corrective		
	resident to ma	ke sandwiches out of			action(s) will be monitored to	,iII	
		t consumes bites to			ensure the deficient practice w nor reocur: The CQI audit too		
	75% of meals				Change in Condition as well a		
	encouragemen				24 Hour Condition Report will		
					utilized daily x 4 weeks, bi-wee		
	Resident #06's	tray card indicated the			x 2 months, and monthly x 3		
		chanical soft diet. 2			months and for 3 quarters		
	_	d. Single serve dishes.			thereafter for any resident who)	
	Fieces of Diea	u. Sirigie serve distles.			has a change in condition. Finding from the CQI process	will	
	Am intermitation	ith the Dietem, Manager			be reviewed monthly and an		
		ith the Dietary Manager			action plan will be implemente	d	
		2:39 P.M., indicated she			for threshold below 95%.5) By	y	
		iet recommendations			what date the systemic change		
		Resident #96 and			will be complete: The correcti		
	could not find a	a physicians order for a			actions will be completed on o	r	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155160	A. BUI	LDING	00	COMPL 02/14/	
		155100	B. WIN		DDDEGG GITW GT TE ZIN COSS	02/14/	2012
NAME OF F	PROVIDER OR SUPPLIER			990 N 1	ADDRESS, CITY, STATE, ZIP CODE		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710		t diet. The Dietary		1110	before 3/15/2012		DATE
		ated "probably what					
	_	me and a nurse					
		diet and decided to try					
	a mechanical s	oft to see if her intakes					
	would improve,	but we did not follow					
	_	e order". The Dietary					
	_	ated there was no					
	documentation	•					
		t diet change for					
	Resident #96 or why. The Dietary Manager indicated she did not know						
	when Resident						
		egular to mechanical					
	soft.						
	An interview wi	th the Dietary Manager					
	on 2/14/12 at 9	:37 A.M., indicated					
		lid not do well with					
	_	ular diet, so she, and					
		to try the mechanical					
		ursing measure, to see 's intakes would					
		Dietary Manager					
	•	lid not receive a					
		er for the diet change,					
	• •	t discuss the diet					
		e Registered Dietician.					
	-	rview with Family		İ			
	, ,	d Family member #2 of					
		n 2-9-12 at 2:09 p.m.,					
	indicated the re	esident had been sent					
	to the hospital	and was treated for					
		nd the resident's mouth					
	had improved.	The family members					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155160	B. WIN			02/14/2012	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			6TH ST ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DA	TE
	indicated when	the resident returned					
	to the facility, th	ne resident's mouth					
	started getting	bad again. The family					
	member indicat	ted they insisted the					
	facility treat the	resident's mouth					
	sores. Family n	nember #1 indicated					
		ne resident's dentures					
	and cleaned the	em today.					
	During chase:	ition and interview on					
	During observation and interview on 2-13-12 at 9:06 a.m., Resident #20 was lying in bed with her dentures in						
	, , ,	resident's dentures					
		and had a film on					
	l	dent's tongue was					
		swollen. The resident					
	_	ad thrush and was					
		ig she had it. The					
		ed the facility gives her					
		wish in her mouth and					
		esident indicated her					
	•	sore and she also had					
	sores on her gu	ums. Resident #20					
	indicated the fa	cility was supposed to					
	take the dentur	es out and soak them					
	over night. Duri	ing observation of the					
		ure cup, it was dated					
	1-22-12 and ma						
		e. The denture cup					
		dry. Resident #20					
		ad been sleeping in					
		nce Family member #1					
		on Thursday. This					
		entures had not been					
	taken out of he	r mouth for 3 days.					

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	NOF CORRECTION IDENTIFICATION NUMBER: 155160	(X2) MULTIPLE CC A. BUILDING B. WING	00 		LETED -/2012
	PROVIDER OR SUPPLIER BROOKE REHABILITATION CENTRE & SUITES	STREET A 990 N 1	ADDRESS, CITY, STATE, ZIP CO 16TH ST ASTLE, IN 47362	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Review of Resident #20's Medication Administration Record (MAR) on 2-13-12 at 9:39 a.m., indicated the resident was to have her dentures out of her mouth unless she was eating. Interview with CNA #2 on 2-13-12 at 9:40 a.m., indicated the information about Resident #20's dentures not being in her mouth should have been on the CNA assignment sheet. Review of the CNA assignment sheet with CNA #2 did not indicate any information about the resident not having her dentures in except when she was eating. CNA #2 indicated she did not know how information like that was supposed to be communicated to the CNAs. CNA #2 indicated she did not know Resident #20 had false teeth. Interview with LPN #5 on 2-13-12 at 9:53 a.m., indicated the reason Resident #20 was not have dentures in except while eating was because the resident's mouth got sore easy and she had thrush. LPN #5 indicated it was also to ensure the resident's dentures were cleaned. LPN #5 provided a copy of the CNA assignment sheet and there was no documentation for Resident #20 to have her dentures out of her mouth.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155160	B. WINC			02/14/	2012
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
STONE	BROOKE REHABIL	ITATION CENTRE & SUITES			6TH ST ASTLE, IN 47362		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on 2-13-12 at resident's diag were not limited Obstructive Put (COPD), arthricanxiety, deprefailure, Urinary difficulty voiding induced hypersugar). The Minimum assessment for 1-17-12, indicated the reson. The local hosp Resident #20 indicated the resores in her mulikely secondal inhales. She was magic mouthwalesions and or seemed to hell being discharg with a prescription.	allmonary Disease tis, osteoarthritis, ssion, congestive heart a Tract Infection (UTI), ag and history of steroid glycemia (high blood Data Set (MDS) ar Resident #20 dated ated the following: as summary score was a intact and personal ding brushing teeth) assistance of one Dital discharge note for dated 1-10-12, esident complained of outh, this was most ary to the steroids she as started on Mary's ash (treatment for oral al pain) and that p her. The resident was ged back to the facility					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/14/2012	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		CASTLE, IN 47362	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
	dated 1-10-12, was ordered M mouthwash 5 n	nilliliters every six last dose was given on			
	The facility's ph Resident #20 d	nysician orders for lated 1-10-12			
	indicated no or	der for Mary's magic			
	mouthwash. The orders were signed by LPN #9. The physician orders were not signed by the physician.				
	dated 1-10-12 a Resident #20 h hospital. The d	ote for Resident #20 at 3:45 p.m., indicated ad returned from the octor orders were pital and faxed to the the doctor.			
	dated 1-25-12 a the resident's n This was repor	ote for Resident #20 at 6:39 p.m., indicated nouth was sore again. ted to the doctor an answer back about			
	dated 1-25-12 a a call was place The resident's resident to have mouthwash. Th	ote for Resident #20 at 7:11 p.m., indicated ed to resident's family. family requested the e Mary's magic ne family member was e physician was out of			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	00	COMPLETE	
		155160	B. WING			02/14/20 ⁻	12
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
STONED	DOOKE BEHABILI	TATION CENTRE & SUITES			6TH ST ASTLE, IN 47362		
					45 ILE, IN 47 302		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE TA	AG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	OMPLETION DATE
		here would be a follow					
	up in the morning with the office.						
		ng mar are emee.					
	The fax sent to	the physician for					
		lated 1-26-12 at 7:50					
	a.m., indicated	the resident					
		a sore throat and					
		ident's family was					
		y's magic mouthwash.					
May we have an order? The physician							
	response was, ok one teaspoon four						
	times a day for	10 days.					
	The progress n	ote for Resident #20					
		at 6:36 p.m., indicated					
	· ·	order for Mary's					
		ash 1 tsp four times a					
	day for 10 days	•					
	Review of the N	MAR for Resident #20					
	dated 1-10-12	through 1-31-12,					
		esident received her					
		ary's magic mouthwash					
		1-27-12 at 6:00 a.m.					
		the resident went 17					
	1	eatment for oral sores					
	1	discharge from the					
	local hospital o	II I-IU-IZ.					
	The physician (order for Resident #20					
		t 12:00 p.m. indicated					
	the resident wa	•					
		en eating until mouth					
	heals.						

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	OF CORRECTION IDENTIFICATION NUMBER: 155160	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/14/2012			
	PROVIDER OR SUPPLIER BROOKE REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE	D BE COMPLETION			
	Interview with RN #10 on 2-14-12 at 10:16 a.m., indicated the procedure for when a resident returned from the hospital was the discharge medication orders were usually faxed to the physician or the physician was called with the list of discharge medications. RN #10 indicated the physician had not signed the physician orders for Resident #20's medication on 1-10-12. The physician services policy provided by the Administrator on 2-14-12 at 1:55 p.m., indicated "A qualified physician supervises the healthcare of every resident." The physician reviews the resident's program of care including medications and treatments. The physician signs and dates all orders. 3.1-35(g)(2)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED 02/14/2012			
		155160	B. WING		02/14/2012
	PROVIDER OR SUPPLIE	R ITATION CENTRE & SUITES	990 N	ADDRESS, CITY, STATE, ZIP CODE 16TH ST CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=G	WELL BEING Each resident in must provide th services to attai practicable physical physical physical with a comprehensicare. A. Based on review and interest unrelies inability to sleed activities of daresidents review met the criteria and managem. B. Based on or review and interest a resident a resident and managem. B. Based on or review and interest a resident a resident and managem. The record reviewed on 2 revie		F0309	F-309 Provide Care/Services Highest Well Being1) What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice: Reside #6 has been evaluated by physician and therapy, pain assessment completed, pain medication review and care plant review, no new pain medication orders noted. Resident #20 has been evaluated by physician, assessment completed, medication review and care plant review. How other residents having the potential to be affected by the same deficient practice be identifed and what correctivation(s) will be taken: All residents have the potential to affected by the alleged deficient practice. The nursing staff will re-educated by the DNS/desig (3/6/12) on pain management policy, pain assessment, non-medication interventions for pain, and change in condition, and review SBAR uitlization for new or worsening conditions with physician / family notification. Residents pain assessments with the provided	nts y nt an on as pain an s cted will ve be nt l be inee

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00 COMPLETED		
		155160	A. BUILDING	<u> </u>	02/14/2012
			B. WING	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEI	₹			
CTONES	DOOKE DELIABILI	TATION CENTRE & CUITEC		N 16TH ST	
STONEE	SKOOKE REHABILI	TATION CENTRE & SUITES	NEW	CASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	depression and rhabdomyolysis			be reviewed by DNS/ design	
	(degeneration of skeletal muscle			for completion and assessm	
		traumatic injury,		up dated if indicated. Licens	sed
		tion, or stroke).		nurse will fill out a Situation	
	CXCCCCIVC CXCI	tion, or otrono).		Background Assessment	nd l
	Dogident #61a	most recent MDS		Recommendation (SBAR) a notify physician of a new or	iiu
				worsening condition, add res	sident
	`	a Set), assessment,		to 24 hour condition report for	
		indicated the following:		going monitoring Residen	
	"- BIMS (brief i	nterview for mental		pain assessments reviewed	
	status), 15, a s	core of 13 to 15		less than quarterly by IDT.	All
	indicates cognitively intact			residents who experience ch	nange
	- pain, on scheduled pain medication,			in pain will have physician	
	yes	autou paint moutouson,		notification. All residents wil	
	*	l (as needed) pain		assessed weekly for mouth	
		, , ,		and physician will be notified	
	medication, ye			indicated per assessment.3) What measures will be put in	
	- interventions	other than medication,		place or what systemic chan	
	yes			will be made to ensure that t	_
	- pain presence	e, yes		deficient practice does not re	
	- how often exp	periencing pain,		The nursing staff will be	
	frequently			re-educated by the DNS/des	signee
		otion of pain scale,		(3/6/12) on pain management	nt
	moderate"	, , , , , , , , , , , , , , , , , , ,		policy, pain assessment,	
	moderate			non-medication interventions	
	Docident #6'e	nara nian datad		pain, and changes in conditi	
		care plan dated		and review SBAR utilization new or worsening conditions	
		ated "Problem,		physician / family notification	
	resident has pa			Residents pain assessments	
		bility and osteoporosis		assessments will be reviewe	
	and a history of	f rhabdomyolysis.		completion by DNS/designe	
	Goal, will have	relief of pain within 30		and assessments up dated i	
	to 60 minutes	·		indicated. Licensed nurse w	
		ninister medications as		out a SBAR and notify physi	
		nedication interventions		of a new or worsening condi	
	· ·			add resident to 24 hour cond	
		uiet environment,		report. SBAR will be review	
	•	dered and notify		daily by IDT and 24 hour rep	
	physician if pai	n is unrelieved and/or		monitoring per IDT to identif	y and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155160	B. WIN			02/14/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	S.		1	6TH ST	
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	ì ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	worsening." Resident #6's r Assessment (ir dated, 11/29/1 following "- is the resider pain medication - are you curre yes - have you had time in the last - over the past it hard for you t - over the past limited your da because of pai - what is the loc shoulder - please rate th worst pain over question not m - how much of experienced pai last 5 days, free - type of pain, a - what causes y movement." Resident #6's p 3/6/11, indicate (milligrams), by and Ibuprofen	most recent "Pain nterviewable resident)", 1, indicated the nt currently on routine ns, yes ntly experiencing pain, pain or hurting at any 5 days, yes 5 days, has pain made to sleep at night, yes 5 days, have you y-to-day activities n, yes cation of your pain, left e intensity of your the last 5 days, (this arked) the time have you ain or hurting over the quently			add residents to 24 hour condi- report . 24 hour report monitor per IDT for physician and fami- notification. Therapy screen for any resident with increased or unresolved pain.4) How the corrective action(s) will be monitored to ensure the defici- practice will not recur: The CC audit too for Change in Condti- Pain Management, and 24 Ho Condition Report will be utilized daily x 4 weeks, bi-weekly x 2 months, and monthly x 3 mont- and for 3 quarters thereafter for any resident who has pain / chnage in condition. Finding f CQI process will be reviewed monthly and an action plan will implemented for threshold belo 95%5) By what date the syste changes will be complete: The corrective actions will be completed on or before 3/15/1	ent QI on, ur d hs or rom I be ow emic e

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155160	A. BUILDING		00	COMPL 02/14/	
		155100	B. WING			02/14/	ZU 1Z
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAC		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		physician's "History and	IAC	'	,		DATE
		ination" dated 3/5/11					
	indicated "Past History" included, but was limited to, "addiction to pain						
	medication."						
		Nurse's Medication"					
	with documents						
		dicated "2/14/12,					
medication, Ibuprofen, reason, general body ache, results/response, (left blank)."							
	(1010 010.111)						
	Interview with F	Resident #6 on 2/9/12					
	•	dicated she was					
	_	and shoulder pain.					
		dicated she receives					
	-	er left arm pain and the					
		ery little. Resident #6 she receives Tylenol					
		he Tylenol does not					
		t all. She indicated					
		e nurses because it					
	keeps her awal	ke at night, it hurts too					
		ry to hold onto the					
		and she just does not					
	feel like doing a	anything.					
	On 2/14/12 at 0	9:45 a.m., Resident #6					
		n bed. Resident #6					
		ith her right hand to her					
		nd and stated "my left					
		ad and it kept me					
		the night last night."					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155160	B. WING		02/14/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE 16TH ST	
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
IAU	During interview a.m., indicated in her left arm a she indicated of it her pain was Ibuprofen does morning and it much if any. It the pain but it is about it when it sleep much last pain." During interview a.m., the Assist (ADON) indicated has not been rephysician that is pain medication changed becauthistory of additional medication. During interview a.m., staff Physical therapexperience pain Physical Therapelint had been splint had been splint had been specificated.	w with 2/14/12 at 9:50 she was having a pain and hand right now and an a pain scale of 0-10 an 8. She stated "the not help, I had it this just didn't help that try not to think about a hard to not think is hurting. I did not at night because of the w on 2/14/12 at 10:40 tant Director of Nursing and Resident #6's pain exported to the she is aware of, but the had not been use Resident #6 had a	IAU		DATE
	dated 3/10, pro	ed "Pain Management" vided by the n 2/14/12 at 1:55 p.m.,			

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	OF OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155160	B. WIN	IG		02/14/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
OTONED				990 N 1			
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		y the Administrator to					
		rrent policy, indicated					
	_	policy of American					
		nities to provide,					
	·	ychosocial well being,					
		management. It is the					
		f the facility to ensure					
		ent is assessed for					
	pain, and the e	• •					
	medication, wh	. •					
		nfortable and pain free					
	•	rocedure, residents are					
	•	ain upon admission,					
		vith a significant					
	_	esident's condition					
		set of pain. The					
	• •	lines will be used when					
	assessing pain	, using the specific					
	pain assessme	nt. Interviewable					
	•	ain management					
	program will be	determined based					
	upon the reside	ent's verbal response					
	to the question						
		erviewable resident.					
	Pain medicatio	ns will be prescribed					
	and given base	d upon the intensity of					
	the pain as follo	ows: mild, moderate,					
	severe, very se	vere, horrible.					
	B.) During inter	view with Family					
	member #1 and	d Family member #2 of					
	Resident #20 c	n 2-9-12 at 2:09 p.m.,					
	the family indic	ated they had talked					
	with the facility	numerous times about					
	· ·						

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	OF GODDECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155160	B. WIN	IG		02/14/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		sing weight and having					
		he family members					
		esident had been sent					
	•	and was treated for the					
		nd the resident's					
		roved. The family					
		ated when the resident					
		facility, the resident's					
	1	getting bad again. The					
	family member	indicated they insisted					
	the facility treat	the resident's mouth					
	sores. The fam	ily members indicated					
	the resident ha	d not been able to eat					
	due to the mou	th sores. The family					
	members indicate	ated the resident was					
	little and weak	now because she had					
	been unable to	eat. The family					
	members indicate	ated the facility does					
	not give the res	sident assistance with					
	oral hygiene ar	nd they felt the poor					
	oral hygiene als	so contributed to the					
	resident's sore	mouth. Family					
	member #1 ind	icated the resident's					
	dentures were	"a mess" when they					
	came to the fac	cility today. Family					
	member #1 ind	icated they cleaned					
	the dentures fo	r the resident.					
	During observa	ition and interview on					
	_	a.m., Resident #20					
	was lying in be	d with her dentures in					
	her mouth. The	resident's dentures					
		and had a film on					
	''	dent's tongue was					
		swollen. The resident					
							<u> </u>

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155160	B. WIN	IG		02/14/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ad thrush and was					
		ig she had it. The					
		ted she had lost a lot of					
	•	e her mouth had been					
		as unable to eat. The					
		ted she did not feel like					
		other contributing					
		eight loss; her mouth					
	was too sore to	eat. The resident					
	indicated the fa	icility gives her					
	something to s	wish in her mouth, and					
	it helps. The re	esident indicated her					
	mouth was still	sore and she also had					
	sores on her gu	ums. The resident					
	indicated she h	ad sour kraut the other					
	day, and it was	the first food she					
	could really tas	te since having thrush.					
	The resident in	dicated ever since she					
	had thrush, not	hing tastes right. The					
	resident indicat	ted food does not have					
	any taste. The	resident indicated the					
	last time the fa	cility weighed her, she					
	weighed 108 p	ounds. The resident					
	indicated she u	sually weighed a lot					
	more than that.	The resident indicated					
	she hoped she	did not lose any more					
	weight. Reside	nt #20 indicated her					
	dentures had n	ot been cleaned since					
	Family membe	r #1 cleaned them last					
	week. Residen	t #20 indicated the					
	facility was sup	posed to take the					
		nd soak them over					
	night. During of	bservation of the					
	"	ure cup, it was dated					
	1-22-12 and ma	•					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160			LDING	NSTRUCTION 00	(X3) DATE COMPL 02/14 /	ETED	
	PROVIDER OR SUPPLIER	TATION CENTRE & SUITES	.	990 N 1	ODDRESS, CITY, STATE, ZIP CODE 6TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	was completely indicated she had dentures clean mouth for three observation, Cl Resident #20's the resident was resident indicated the resident was resident indicated ready to get up. Interview with 0 9:25 a.m., indicated Resident's dentures should thought even in them out at nig CNA #2 indicated dentures had not CNA #2 indicated already have the starts work #2 indicated so with their denture indicated the fatablets to soak in; the resident provide the clean	NA #2 came into bedroom and asked if as ready to get up, the sed no she was not yet. CNA #2 on 2-13-12 at sated she cleans ures daily. CNA #2 dent #20 had not ate of. CNA #2 indicated ow when resident's d be soaked; she g shift should take ht and soak them. led Resident #20's ot been cleaned today. led a lot of residents heir dentures in when in the morning. CNA lone residents sleep					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155160	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 14/2012
		133100	B. WING		_	17/2012
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZI	P CODE	
OTONES	DOOKE DELIABIL	TATION CENTRE & OUTES		16TH ST		
	KOOKE KEHABILI	TATION CENTRE & SUITES	NEW C	CASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF O		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	HE APPROPRIATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	-	changed every three				
		bservation with CNA #2				
	at this time, there were three boxes of					
	1	acterial with baking				
		ent single tablet boxes				
		per box in the storage				
		stated " I guess we do				
	have them."					
	Daview of D	: doub #00lo M = -!! !!				
		ident #20's Medication				
		Record (MAR) on				
		a.m., indicated the				
		have her dentures out				
	of her mouth u	nless she was eating.				
	Interview with 0	CNA #2 on 2-13-12 at				
		cated the information				
		t #20's dentures not				
		outh should have been				
	_	signment sheet.				
		CNA assignment sheet				
		id not indicate any				
		out the resident not				
		itures in except when				
	_	g. CNA #2 indicated				
		ow how information like				
	that was suppo					
		to the CNAs. CNA #2				
		did not know Resident				
	#20 had false t					
	Interview with I	LPN #5 on 2-13-12 at				
		cated the reason				
		vas not have dentures				
		eating was because				

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	OF CORRECTION OF CORRECTION 155160 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/14/2012		
	PROVIDER OR SUPPLIER BROOKE REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	the resident's mouth got sore easy and she had thrush. LPN #5 indicated it was also to ensure the resident's dentures were cleaned. LPN #5 provided a copy of the CNA assignment sheet and there was no documentation for Resident #20 to have her dentures out of her mouth. Review of the record of Resident #20 on 2-13-12 at 9:54 a.m., indicated the resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), arthritis, osteoarthritis, anxiety, depression, congestive heart failure, Urinary Tract Infection (UTI), difficulty voiding and history of steroid induced hyperglycemia (high blood sugar).					
	The Minimum Data Set (MDS) assessment for Resident #20 dated 1-17-12, indicated the following: cognitive status summary score was 15- cognitively intact and personal hygiene (including brushing teeth) was extensive assistance of one person. The local hospital discharge note for					
	Resident #20 dated 1-10-12, indicated the resident complained of sores in her mouth, this was most likely secondary to the steroids she					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160		(X2) MU A. BUILI		NSTRUCTION 00	(X3) DATE :	ETED	
		155160	B. WING			02/14/	2012
	PROVIDER OR SUPPLIE	R ITATION CENTRE & SUITES		990 N 1	ADDRESS, CITY, STATE, ZIP CODE 6TH ST ASTLE, IN 47362		
(X4) ID	1	STATEMENT OF DEFICIENCIES	1	ID	,		(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	F	REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	magic mouthw lesions and or seemed to hel	vas started on Mary's vash (treatment for oral al pain) and that p her. The resident was ged back to the facility otion for this.					
	the local hospidated 1-10-12 was ordered Monuthwash 5	milliliters every six last dose was given on					
	Resident #20 indicated no o mouthwash. T by LPN #9. Th	hysician orders for dated 1-10-12, rder for Mary's magic he orders were signed by the physician orders ed by the physician.					
	dated 1-10-12 Resident #20 hospital. The d	note for Resident #20 at 3:45 p.m., indicated had returned from the doctor orders were spital and faxed to the I the doctor.					
	dated 1-25-12 the resident's This was repo	note for Resident #20 at 6:39 p.m., indicated mouth was sore again. rted to the doctor g an answer back about					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 02/14	LETED	
	PROVIDER OR SUPPLIER	TATION CENTRE & SUITES		990 N 1	DDRESS, CITY, STATE, ZIP CODE 6TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	dated 1-25-12 a call was place. The resident to have mouthwash. The notified that the the office and the up in the mornion of the fax sent to the resident #20 da.m., indicated complained of a mouth. The reserved are response was, times a day for the progress of the received are magic mouthway for 10 days. Review of the Mated 1-10-12 indicated the refirst dose of Mated 1-10-12 indicated the refired 1-10-12 indicated the refirst dose of Mated 1-10-12 indicated	a sore throat and ident's family was y's magic mouthwash. In order? The physician ok one teaspoon four 10 days. ote for Resident #20 at 6:36 p.m., indicated order for Mary's ash 1 tsp four times a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155160		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 4/2012	
	PROVIDER OR SUPPLIER	TATION CENTRE & SUITES	990 N 1	NDDRESS, CITY, STATE, ZIP COE 6TH ST ASTLE, IN 47362	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	weighed 122 per the resident were for Resident #2 indicated the respondent shortly large pill. The resident were weak. The loss in last seventhin. The resident per thrush. The physician of dated 2-9-12 are the resident was dentures in when last. Interview with Foundation or when a resident was the resident was the medication or designed with the medications. For physician had not the physici	r Resident #20 0-1-11, the resident ounds, and on 2-13-12 eighed 107 pounds. gency Room) record 20 dated 2-8-12, esident had a syncope of after choking on a resident stated she felt eresident had weight eral months and was ent had a decrease in severe episode of a sonly to have en eating until mouth RN #10 on 2-14-12 at icated the procedure dent returned from the ene discharge ers were usually faxed in or the physician was list of discharge RN #10 indicated the not signed the res for Resident #20's				

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PRINTED: 03/15/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160			00	COMI	PLETED 4/2012
	PROVIDER OR SUPPLIEI BROOKE REHABILI	TATION CENTRE & SUITES	990 N 1	ADDRESS, CITY, STATE, ZIP 16TH ST ASTLE, IN 47362	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	3.1-37(a)					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155160	B. WIN			02/14/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			I6TH ST ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	483.25(a)(3) ADL CARE PRO RESIDENTS A resident who is of daily living rec to maintain good personal and ora Based on obse record review, f assist a resider assistance with with oral care for reviewed for ac 2 who met the daily living (Resident #20 or the family indicated the resident los mouth sores. T indicated the resident had imp members indicated returned to the mouth started g	VIDED FOR DEPENDENT s unable to carry out activities reives the necessary services nutrition, grooming, and all hygiene. rvation, interview and the facility failed to not who needed activities of daily living for 1 of 2 residents ctivities of daily living of criteria for activities of sident #20).	F03		F-312 ADL Care Provided For Dependent Residents1) What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice: Resider #20 dentures removed and cleaned and removed after meto facilitate mouth healing.2) Hother residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected by the alleged deficient practice. The nursing staff will re-educated by DNS/designee (3/6/12) on resident hyigene, care, denture care including cleaning and storing of denture oral assessment, utilization of CNA assignment sheet contents, location of hyigene supplies, utilizing Behavior Incident Rev (BIR) with residents refusals o care, and documentation / 24 hour condition report. License nurse will complete weekly ora skin assessment. Charge nurse will give verbal report on reside	nts y nt eals How be oral es, iew f	
	sores. The fam	the resident's mouth ily members indicated d not been able to eat			identified on 24 hour condition report / change in condtion to assigned CNA and follow up		

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155160	B. WIN			02/14/	2012
NAME OF F	ROVIDER OR SUPPLIER	8		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					I6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	due to the mouth sores. The family				assignment completion. Char nurse will check CNA has	y c	
	members indicated the resident was				appropraite CNA assignment		
		now because she had			sheet. Staff Developement		
		eat. The family			Coordinator will orient all new		
		ated the facility does			hired nursing staff to location of		
	_	sident assistance with			supplies. CNA binder in place with denture cup replacing	;	
	, , ,	nd they felt the poor			schedule. CNA assignment		
		so contributed to the			sheet updated 5 days week a	s	
	resident's sore	<u> </u>			new orders / interventions occ	ur.	
		licated the resident's			All residents will have oral		
		"a mess" when they			assesssment completed week if physician notification if	ily,	
		cility today. Family			indicated.3) What measures v	will	
	member #1 ind	licated they cleaned			be put into place or what syste		
	the dentures fo	or the resident.			changes will be made to ensu		
					that the deficient practice does	3	
	During observa	ation and interview on			not recur: The nursing staff		
	2-13-12 at 9:06	3 a.m., Resident #20			will be re-educated by DNS/designee (3/6/12) on		
	was lying in be	d with her dentures in			resident hyigene, oral care,		
	her mouth. The	e resident's dentures			denture care including cleanin	g	
	appeared dirty	and had a film on			and storing of dentures, oral		
	them. The resid	dent's tongue was			assessment, utilization of CNA	Ą	
	bright red and	swollen. The resident			assignment sheet and assignment sheet contents,		
	indicated she h	ad thrush and was			location of hyigene supplies,		
	unsure how lor	ng she had it. Resident			utilizing BIR with residents		
		ner dentures had not			refusals of care, and		
	been cleaned s	since Family member			documentation / 24 hour cond	ition	
		m last week. Resident			report. Licensed nurse will complete weekly oral/skin		
	#20 indicated t	he facility was			assessment, IDT to audit wee	klv	
		ke the dentures out			for completion. Charge nurse		
		over night. During			give verbal report on residents		
		the resident's denture			identified on on 24 hour condit	tion	
		ed 1-22-12 and marked			report/ change in condition to assigned CNA and follow up or	vn.	
	-	nt's name. The			assignment completion. Char		
		as completely dry.			nurse will check CNA has	J-	
	•	ndicated she had been			appropriate CNA assignment		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155160	B. WIN			02/14/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEI	₹		990 N 1	6TH ST	
STONEE	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
		dentures since Family			sheet. Staff development coordinator (SDC) will orient a	ıı
	member #1 cleaned them on Thursday. This indicated the resident				new hired nursing staff to loca	
					of supplies. CNA binder in pla	
		er dentures cleaned or			with denture cup replacing	
		er mouth for three days.			schedule will be reviewed wee	kly
	_	ation, CNA #2 came			by DNS/designee CNA assignment sheet updated 5 d	31/6
		20's bedroom and			week as new orders /	ays
		sident was ready to get			interventions occur per ADNS	,
	up, the residen	t indicated no she was			Charge nurse will make chang	
	not ready to ge	et up yet.			and up dates on weekend. BI	R
					review daily per IDT with care	
	Interview with	CNA #2 on 2-13-12 at			plans up dated as indicated. Daily rounds every shift, per	
	9:25 a.m., indi	cated she cleans			charge nurse to ensure CNA	
	resident's dent	ures daily. CNA #2			assignment sheets are	
	indicated Resid	dent #20 had not ate			followed.4) How the corrective	e
	breakfast toda	y. CNA #2 indicated			action(s) will be monitored to	
		ow when resident's			ensure the deficient practice w	
	dentures shoul	d be soaked; she			not recur: Skills validation for oral care/ dentures will be	
		g shift should take			completed on all CNAs and ar	nv
	_	ht and soak them.			new hire CNAS. per SDC	,
	_	ted Resident #20's			Weekly skin/oral assessment	
		not been cleaned today.			audit weekly for completion pe	
		ted a lot of residents			DNS/ADNS The CQI audit to for Accomodation of Needs wi	
		neir dentures in when			be utilized daily x 4 weeks.	"
	1	in the morning. CNA			bi-weekly x 2months, and mor	ithly
		ome residents sleep			x 3 months and for 3 quarters	
		ures in. CNA #2			thereafter. Findings form the	
		acility did not have			CQI process will be reviewed	l bo
		the residents' dentures			monthly and an action plan will implemented for threshold below	
		s' families had to			95%.5) By what date the syste	
	· ·	aning tablets for the			changes will complete: The	
	l •	A #2 indicated denture			corrective actions will be	_
		e changed every three			completed on or before 3/15/1	2.
	1					
		bservation with CNA #2				
	at this time, the	ere were three boxes of				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155160	B. WIN			02/14/	2012
NAME OF P	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			6TH ST ASTLE, IN 47362		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		· · · · · · · · · · · · · · · · · · ·		TAG	DEI ICIERCI)		DATE
TAG	IX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			TAG	DEPICIENCY		DATE
		to the CNAs. CNA #2 lid not know Resident					
	#20 had false t	eeth.					
	9:53 a.m., indic Resident #20 v in except while the resident's r and she had th	LPN #5 on 2-13-12 at cated the reason was not have dentures eating was because mouth got sore easy rush. LPN #5 a also to ensure the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160		(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 14/2012			
	ROOKE REHABILI	TATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
TAG	resident's dentil LPN #5 provide assignment should assignment should assignment should assignment should assignment should assignment should assign were not limited. Obstructive Pu (COPD), arthritanxiety, depressible failure, Urinary difficulty voiding induced hypergray sugar). The Minimum I assessment for 1-17-12, indicated cognitive status 15- cognitively hygiene (included)	ures were cleaned. ed a copy of the CNA eet and there was no for Resident #20 to lifes out of her mouth. record of Resident #20 et a.m., indicated the hoses included, but d to, Chronic Imonary Disease elis, osteoarthritis, esion, congestive heart Tract Infection (UTI), g and history of steroid glycemia (high blood Data Set (MDS) r Resident #20 dated ted the following: es summary score was intact and personal ling brushing teeth) assistance of one	TAG	DEFICIENCY	APPROPRIATE	DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155160	B. WIN			02/14/2	2012
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315 SS=D	483.25(d) NO CATHETER BLADDER Based on the resident who entindwelling cathet the resident's clin that catheterizati resident who is in receives approprious prevent urinar restore as much possible. Based on obserecord review, provide a residissues and a hill Infections (UTI) incontinence casampled for incontinence cas	sident's comprehensive facility must ensure that a ers the facility without an er is not catheterized unless nical condition demonstrates on was necessary; and a noontinent of bladder riate treatment and services y tract infections and to normal bladder function as rvation, interview and the facility failed to ent who had skin story of Urinary Tract with timely are and proper are for 1 of 1 resident continence care in a e of 15 (Resident #20). The family member #1 mber #2 of Resident at 2:09 p.m., indicated perineal area was a sore. The family atted the resident of that her perineal and burned. The family atted when they visit ey find the resident	F03		F-315 No Cathether, Prevent UTI, Restore Bladder1) What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice: Resider #20 will receive incontinent ca every 2 hours per policy, with appropriate pericare, and treatment order in place.2) House the potiental to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected by the alleged deficien practice. The nursing staff will re-educated by DNS/designee (3/6/12) on perineal care policy check/changing an incontinent resident, skin care / preventati treatments, weekly skin assessments, review of clease products and usage guidelines and preventative barriers. Pericare validations will be completed on all CNAs by	nts y nt re be nt l be y, t ve	03/15/2012

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155160	B. WIN			02/14/2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	I
NAME OF F	PROVIDER OR SUPPLIER				6TH ST	
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	indicated the re	esident was unable to			DNS/SDC by 3/15/12. Skin	
	take herself to the bathroom. Family				assessments completed week	-
	member #2 ind	icated to please look			identifying residents at risk and	d
		s bottom because it			in need of preventative	
	was so red and				treatment. CNAs to notify nur- of resident refusals of incontin	
	was so rea and	. 5515.			care or residents with noted sl	
	Distribution and a large a	Alone and interest according			issues. Refer residents to	
	_	ition and interview with			toileting program when	
		n 2-13-12 at 9:06 a.m.,			appropriate. CNA will apply	
		nelled strongly of urine.	1		preventative barrier to all	
	The resident in	dicated she knew			incontinent residents.3) What	
	when she was	wet from incontinence			measures will be put in place	
	sometimes, but	t not always. The			what systemic changes will be	
	I	ed she did not know			made to ensure that the defici	ent
		to use the bathroom.			practice does not recur: The nursing staff will be	
		dicated she was			re-educated by DNS/designee	<u>.</u>
					(3/6/12) on perineal care polic	
	1	her perineal area. The			check/changing an incontinen	
		ed sometimes the			resident, skin care / preventati	
	I	ve on me and it helps;			treatments, weekly skin	
	"it feels good."				assessments, review of cleans	
					products and usage guidelines	S.
	During observa	ition and interview on	1		Pericare validations will be	
	2-13-12 at 10:1	0 A.M., CNA #6 and			completed on all CNAs by DNS/SDC by	
		providing incontinence			3/15/12. Skin assessments	
		nt #20. Resident #20			completed weekly identifying	
		id not wear depends to			residents at risk and in need o	f
		he was so sore in her			prevtative treatment per licens	
					nurse. CNAs to notify nurse o	f
	l ·	nd the staff said it			resident refusals of incontient	
		r if she left them off			care or residents with noted sl	kin
		n bed. The resident's			issues. Refer residents to	
		t gown and two of			toileting program when appropriate. Charge nurse to	do
	three pads on t	he resident's bed were			daily rounds to ensure	uo
	soaked with uri	ne. When queried			appropirate pericare	
	when the last ti	me the resident was	1		completed.4) How the correct	tive
	checked for inc	ontinence, CNA #6	1		action(s) will be monitored to	
		eximately around eight.			ensure the deficient practice w	vill
	I maioatoa appit	minatory around orgin.				ĺ

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPLE	
		155160	A. BUII B. WIN			02/14/2	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				6TH ST		
STONEB	ROOKE REHABILIT	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
IAG		idicated she had not		IAG	not recur: Pericare validations		DATE
<u> </u>		et today; the staff			completed on all CNAs by		
		nanged her last night.			DNS/SDC by 3/15/12 and		
		ed the resident was			quarterly thereafter. Skin	h.,	
<u> </u>	not wet this mo				assessments completed week per licensed nurse and audited	-	
	indicated they r	_			per IDT weekly for	-	
<u> </u>	•	continence every two			completeion. The CQI audit to		
<u> </u>		dent's perineal area			for Accomodation of Needs will be utilized daily x 4 weeks,		
<u> </u>	was observed to	o be pink and red.			bi-weekly x 2 months, and		
<u> </u>	CNA #6 indicate	ed "yes the resident's			monthy x 3 months for 3 quarte		
	bottom is norma	ally that red." CNA #6			thereafter. Findings from the (
	washed the res	ident's perineal area			process will be reviewed mont and an action plan will be	niy	
	•	Iried the resident. CNA			implemented for threshold belo	ow	
<u> </u>	_	sing the resident			95%5) By what date the syste		
<u> </u>	_	the soap off. CNA #6			changes will be complete: The	Э	
<u> </u>	•	lid not rinse the soap			corrective actions will be completed on or before 3/15/1:	2.	
<u> </u>		because the resident			Completed on all balance of total		
<u> </u>		ot have to; it was a no					
<u> </u>	•	servation of the bottle					
<u> </u>	· •	ed to rinse soap off.					
		nd got more wash ed the resident's					
		d did not rinse the					
<u> </u>		either CNA dried the					
<u> </u>	_	r the soap was rinsed					
<u> </u>	off. CNA #6 and	·					
		ident #20 into her					
		e resident's wheelchair					
	did not have a	pressure reducing					
	•	hen queried if any					
	type of moisture	e barrier was					
<u> </u>	supposed to be	used, CNA #3					
<u> </u>	indicated Resid	ent #20 did not have					
		rier cream that was					
	supposed to be	applied after					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155160			LDING	NSTRUCTION 00	(X3) DATE COMPI 02/14	LETED	
	PROVIDER OR SUPPLIER	TATION CENTRE & SUITES	p. 1111	990 N 1	ODDRESS, CITY, STATE, ZIP CODE 6TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Of Nursing (AD 2:38 p.m. indicated perineal area we ADON indicated and the resider problems with a indicated CNAs know if a reside always being rewould tell her a indicated she we therapy look at cushion for her ADON indicated evaluated reside cushion device nursing did the mattresses. The CNAs could get the supply roor CNAs could us any residents. She would put it	he Assistant Director (ON) on 2-12-12 at ated Resident #20's vas not always red. The d it got red sometimes, at always has had excoriation. The ADON as should let the nurse ent's perineal area was ed and then the nurse bout it. The ADON vas going to have getting the resident a wheelchair. The d therapy always lents for pressure s in the chair, and evaluations for e ADON indicated t barrier cream out of an. The ADON indicated e barrier cream with The ADON indicated					
	at 9:40 a.m., in physician order treatment to be shift for 7 days	he ADON on 2-14-12 dicated she got a for Resident #20's Calmoseptine every The ADON indicated Resident #20's perineal					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160			JLTIPLE CO .DING G	nstruction 00	(X3) DATE (COMPL 02/14 /	ETED
	PROVIDER OR SUPPLIEI	R ITATION CENTRE & SUITES	•	990 N 1	DDRESS, CITY, STATE, ZIP CODE 6TH ST ASTLE, IN 47362	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	resident's peri	e ADON indicated the area and inner pink with no open					
	on 2-13-12 at 9 resident's diag were not limite Obstructive Pu (COPD), arthri anxiety, depres failure, Urinary difficulty voidin	record of Resident #20 9:54 a.m., indicated the noses included, but d to, Chronic Ilmonary Disease tis, osteoarthritis, ssion, congestive heart Tract Infection (UTI), og and history of steroid glycemia (high blood					
	assessment fo 1-17-12, indica cognitive statu 15 - cognitively extensive assis transfer- exten people, walk in toilet use- exte people, urinary	Data Set (MDS) r Resident #20 dated ated the following: s summary score was r intact, bed mobility- stance of one person, sive assistance of two r room- did not occur, ensive assistance of two r and bowel equently incontinent.					
	6-28-11, indicatincontinent due and at risk for interventions in	for Resident #20 dated ated the resident was to decreased mobility recurrent UTI's. The noluded, but were not st with incontinent care					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	ie survey ipleted 14/2012			
	PROVIDER OR SUPPLIER	TATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	as needed. The care plant 6-28-11, indicated the Administrate p.m., indicated resident, change at the Administrate p.m.	for Resident #20 dated ted the resident had in breakdown related nobility, incontinence, story of skin issues. Instituted, but were peri care after each sode.						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155160	A. BUILDING B. WING	00	COMPLETED 02/14/2012			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE 6TH ST				
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES	NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	dry the area.							
	dry the area. 3.1-41(a)(2)							

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Event ID: QZDZ11

Facility ID: 000080

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155160	B. WIN	G		02/14/	2012
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIER				I6TH ST		
	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCE)		DATE
F0323 SS=D	The facility must environment rem hazards as is poreceives adequal assistance device. Based on obserecord review, for a resident mediprevent choking resident being for 1 of 3 resident accidents, of 8 criteria for accidents, of 8 criteria for accidents, indicated the resident p.m., indicated the resident got che the Emergency members indicated the resident got che the	ensure that the resident hains as free of accident ssible; and each resident te supervision and es to prevent accidents. rvation, interview and the facility failed to give ication in a manner to g, resulting in the transferred to the om (ER) for evaluation ents reviewed for residents who met the dents (Resident #20). Family #1 and Family #20 on 2-9-12 at 2:09 the nurse did not put entassium in 2-8-12 and the locked and was sent to recommendated the resident's always given to her in the staff usually in applesauce. Indicated the staff did	F03	23	F-323 Free Of Accident Hazards/Supervision/Devices 1 What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice: Resider #20 medication has been changed to liquid formulary to faciliate swallowing and has a may crush medication order in place.2) How other residents having the potential to be affect by the same deficient practice be identified and what corrective action(s) will be taken: All residents have the potential to affected by the alleged deficien practice. The nursing staff will re-educated by DNS/designee (3/6/12) on notifying physician a resident choking, obtain order to change medication to liquid appropriate, family notification, place resident on 24 hour coiti report for choking, obtain a macrush order for medications, speech therapy evaluation for follow up assessment. Physic will be notified if choking is identified and orders for liquid medication if available and appropriate. Resident choking will be identified on 24 hour	ted will be of ers if on by	03/15/2012
		esident #20 indicated			condition report for 24 hour		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLET	ED
		155160	B. WIN		-	02/14/20)12
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			I6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e way to the dining			continued follow up and	nv.	
		nurse stopped her and			documentation. Speech thera will be notified to evaluate	ру	
	gave her medic	cine without			residents experiencing choking	n or	
	applesauce an	d "I got choked." The			difficulty swallowing. All reside		
	resident stated	"they always put in			will have a may crush medica		
	applesauce; th	ey must have been in a			order if appropriate per		
	hurry that day.	_			pharmacy.3) What measures		
					be put into place or what syste		
	Interview with I	LPN #1 on 2-13-12 at			changes will be made to ensure that the deficient practice does		
		cated she knew which			not recur: The nursing staff w		
		red their medication in			be re-educated by DNS/design		
	_ ·	m over the years			(3/6/12) on notifying physician		
	1 ' '	•			a resident choking, obtain orde	ers	
	working with th	lem.			to change medication to liquid		
					appropriate, family notification	,	
		record of Resident #20			place resident on 24 hour		
		9:54 a.m., indicated the			condition report for choking, obtain a may crush order for		
	_	noses included, but			medications, speech		
	were not limite	d to, Chronic			therapy evaluation for follow u	р	
	Obstructive Pu	Imonary Disease			assessment. Physician will be		
	(COPD), arthrif	tis, osteoarthritis,			notified if choking is identifed a	and	
	anxiety, depres	ssion, congestive heart			orders for liquid medication if		
	failure, Urinary	Tract Infection (UTI),			available and appropriate. Ord will be reviewed daily by IDT.	ers	
	difficulty voidin	g and history of steroid			Resident choking will be identi	fied	
		glycemia (high blood			on24 hour condition report for		
	sugar).	3			hour continued follow up and		
	1 2.3 2 /.				documentation. 24 hour cond		
	The progress r	note for Resident #20			report will be reviewed daily by		
		t 12:54 p.m., indicated			IDT to recognize residents on		
		ly 12 p.m. the resident			hour condition report. Speech therapy will be notified to evalue		
		•			residents experiencing choking		
	choked on her	-			difficulty swallowing.4) How th	-	
		25 minutes later during			corrective action(s) will be		
		oorted the resident			monitored to ensure the		
		gic and unresponsive.			deficiecnt practice will not recu		
		as found sitting in			The CQI audit tool for 24 Hour	·	
	wheelchair, ab	le to answer questions,			Condition Report as well as		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		155160	B. WIN			02/14/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	6TH ST		
		TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	•		DATE
		nd vitals completed.			Change in Condition will be utilized daily x 4 weeks, bi-we	aklv.	
		idicated her stomach			x 2 months, and monthly x 3	CKIY	
	I	she did not feel well.			months and for 3 quarters		
		family was called and			thereafter for any resident with	ı	
	1	I the resident be sent to			change in condition. Finding f		
	the ER.				the CQI process will be review		
					monthly and an action plan wi implemented for threshold bel		
	The ER record	for Resident #20			95%.5) By what date the syste		
	dated 2-8-12, i	ndicated the resident			changes will be complete: Th		
	had a syncope	episode shortly after			corrective actions will be		
	choking on a la	arge pill. The resident			completed on or before 3/15/1	2.	
	states she feel	s very weak.					
		,					
	The Speech Th	nerapy plan of					
	•	Resident #20 dated					
		7 p.m., indicated the					
		referral was episode of					
		edication resulting in					
	_	The caregiver education					
		ursing to be educated					
		onsuming large pills.					
	1	0 0 .					
		sted to dissolve					
	potassium pill a						
	''	urse stated that was					
	already being o	uone.					
	Interview with I	LPN #1 on 2-13-12 at					
	· ·	licated Resident #20					
		medication put in					
	''	crushed. LPN #1					
		esident took her					
		ole. LPN #1 indicated					
		new Resident #20 had					
	been taking the	em whole. LPN #1					
	indicated she h	nad worked with					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160			NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/14/2012
NAME OF	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE 6TH ST	
STONE	BROOKE REHABILITATION CEN	TRE & SUITES		ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF C (EACH DEFICIENCY MUST BE PEI REGULATORY OR LSC IDENTIFY!)	RCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Resident #20 for a long tin never put her medicine in or crushed it. LPN #1 indicates resident did not like her meapplesauce.	applesauce cated the			
	During interview with Residual 2-13-12 at 11:20 a.m. when she minded her medication in applesauce, the resident I don't mind it being put in applesauce; it is easier for take." "Especially the big put stuck in my throat, they us it in applesauce especially pill."	n queried if n being put t stated "no me to oill, it gets ually do put			
	During interview with LPN 2-13-12 at 11:25 a.m., who explained that the resident she did not mind medication applesauce and especially LPN #1 stated "It is news to is probably talking about he potassium."	en t indicated ons in the big pill, to me; she			
	During interview on 2-13-1 p.m. Speech Therapy (ST) indicated Resident #20 go the potassium pill. The ST most nurses dissolve the pand on the day the resider choked, they did not. The indicated the potassium pi very large pill. The ST indi) #4 t choked on indicated bill for her nt got ST Il was a			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155160	B. WIN			02/14/2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
CTONED	DOOKE BELIABILI	TATION CENTUE & CUITES		990 N 1		
		TATION CENTRE & SUITES		<u> </u>	ASTLE, IN 47362	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	, The state of the	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
1710		ADON this morning		1710		BATE
		ne potassium put on				
	Resident #20's	•				
		Record (MAR) to have				
	that pill dissolve	` '				
		ou.				
	During interviev	w with the ADON on				
		5 p.m., she indicated				
		to educate nurses				
		#20's medication				
	being dissolved	today. The ADON				
	•	vas going to get a				
		or it today and put it on				
	MAR to ensure	•				
	During observa	ition and interview on				
	2-13-12 at 12:4	8 p.m., with LPN #1				
	indicated she h	ad called the				
	pharmacy and	they said it was ok to				
	break Resident	:#20's potassium pill in				
	half. LPN #1 in	ndicated she asked				
	Resident #20 if	she wanted her				
	medication in a	pplesauce, and the				
	resident indicat	ed she did. Resident				
	#20's potassiur	n pill was observed at				
	this time and it	was large and had a				
	score line in the	e middle of it. LPN #1				
	broke Resident	: #20's potassium				
	chloride in half	and placed it in				
	applesauce. Du	uring observation of				
	Resident #20 ta	aking her medication,				
	the resident wa	s having problems				
	getting the med	dication swallowed.				
	LPN #1 gave th	ne resident more				
	applesauce. Re	esident #20 was				

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155160	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/14/2012
	PROVIDER OR SUPPLIER ROOKE REHABILITATION CENTRE & SUITES	990 N 1	ADDRESS, CITY, STATE, ZIP CODE 6TH ST ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	`		CROSS-REFERENCED TO THE APPROP	RIATE
	3.1-45(a)(1) 3.1-45(a)(2)			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155160	B. WIN			02/14/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0325 SS=D	UNAVOIDABLE	RITION STATUS UNLESS					
	assessment, the resident - (1) Maintains acc nutritional status protein levels, ur condition demon possible; and	dent's comprehensive facility must ensure that a ceptable parameters of , such as body weight and nless the resident's clinical strates that this is not nerapeutic diet when there is nlem.					
	record review, the treat and evaluation with sores can inability to eat a resident was all nutrition, for 1 of for nutrition of 8 for nutrition (Reference of the family indicated the resident loss mouth sores. To indicated the resident with the facility the resident loss mouth sores, a mouth had imp	,	F03.	25	F-325 Maintain Nutrition Statu Unless Unavoidable1) What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice: Resider #20 has an order for ensure plus two times daily and reside weight is reviewed weekly in N and has been reviewed by RD Resident #20 has completed of assessment and has new order continue treatment and reasses. 2) How other resident having the potential to be affect by the same deficient practice be identified and what corrective action(s) will be taken: All residents have the potential to affected by the alleged deficient practice. The nusring staff will re-educated by DNS/designee (3/6/12) on physician notification or care, or all assessment, offering alternative meal. Physician will be notified of resident change in condition. Residents with weight changes	nts y the ent IAR IAR IT to tested will we be nt be on ,	03/15/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCT		ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155160	B. WIN	G		02/14/	2012
NAME OF F	PROVIDER OR SUPPLIER	8		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					I6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		facility, the resident's			5% in 30 days and 10% in180 days will be reviewed weekly be		
	1	getting bad again. The			IDT in NAR. RD to assess	J	
		indicated they insisted			residents with weight changes	:/	
		t the resident's mouth			5% in 30 days and 10% in 180)	
		ily members indicated			days. Licensed nurse will		
		d not been able to eat			complete weekly oral assessment. Residents with		
		th sores. The family			change in condition will be add	ded	
		ated the resident was			to24 hour condition report per		
		now because she had			licensed nurse .3) What		
	been unable to	eat. The family			measures will be put into place		
	members indic	ated the facility does			what systemic changes will be		
	not give the res	sident assistance with			made to ensure that the defici- practice does not recur: The	ent	
	oral hygiene ar	nd they felt the poor			nursing staff will be re-educate	ed	
	oral hygiene al	so contributed to the			by DNS/designee (3/6/12) on		
	resident's sore	mouth. Family			physician notification of reside		
	member #1 ind	licated the resident's			change in condition, oral care,		
	dentures were	"a mess" when they			oral assessment, offering alterntive meal. Physician will	bo	
	came to the fac	cility today. Family			notified of resident change in	De	
	member #1 ind	licated they cleaned			condition. IDT will review		
	the dentures fo	or the resident.			physician orders and completi		
					of SBAR daily. Residents with		
	During observa	ation and interview on			weight changes will be review weekly by IDT in	ea	
	2-13-12 at 9:06	3 a.m., Resident #20			NAR. Registered Dietician to		
	was lying in be	d with her dentures in			assess residents with weight		
		e resident's dentures			changes / 5% in 30 days and		
	appeared dirty	and had a film on			10% in 180 days. Licensed no	urse	
	l	dent's tongue was			will complete weekly oral	ill	
		swollen. The resident			assessment, DNS/designee w audit weekly for completion.	···	
	_	nad thrush and was			Residents with change in		
		ng she had it. The			condition will be added to 24 h		
		ted she had lost a lot of			condition report, IDT to review		
		e her mouth had been			daily for completion.4) How the	ne	
		vas unable to eat. The			corrective action(s) will be monitored to ensure the defici-	ent	
		ted she did not feel like			practice will not recur: The C		
		other contributing			audit tool for Change in Condi		
	and there arry	out of the batting			-		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155160	B. WIN	G		02/14/	2012
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
					6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		IAG	as well as 24 Hour Condition		DATE
		eight loss; her mouth eat. The resident			Report will be utilized daily x 4		
	indicated the fa				weeks, bi-weekly x 2 months, a		
		wish in her mouth, and			monthly x 3 months, and for 3		
		esident indicated her			quarters thereafter for any resident with cahnge in conditi	on	
		sore and she also had			Findings from the CQI process		
		ums. The resident			will be reviewed monthly and a	ın	
	_	ad sour kraut the other			action plan will be implemented		
		the first food she			for threshold below 95%.5) By what date the systemic change		
	1 -	te since having thrush.			will be complete: The corrective		
	1	dicated ever since she			actions will be completed on o		
	had thrush, not	hing tastes right. The			before 3/15/12.		
		ed food does not have					
	any taste. The	resident indicated the					
	last time the fac	cility weighed her, she					
	weighed 108 pe	ounds. The resident					
	indicated she u	sually weighed a lot					
	more than that.	The resident indicated					
	she hoped she	did not lose any more					
	weight. Reside	nt #20 indicated her					
	dentures had n	ot been cleaned since					
		r #1 cleaned them last					
		t #20 indicated the					
		posed to take the					
		nd soak them over					
	"	bservation of the					
		ure cup, it was dated					
	1-22-12 and ma						
		e. The denture cup					
	' '	dry. Resident #20					
		ad been sleeping in					
		nce Family member #1					
		on Thursday. This esident had not had her					
	dentures clean	ed or taken out of her					

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PRINTED: 03/15/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155160	B. WIN			02/14/	2012
NAME OF F	PROVIDER OR SUPPLIER	٤			ADDRESS, CITY, STATE, ZIP CODE		
CTONED	DOOKE BELIABILE	TATION CENTRE & CUITEC			6TH ST		
STONER	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BLI ICILIACI)		DATE
	mouth for three	-					
	· ·	NA #2 came into					
		bedroom and asked if					
		is ready to get up, the					
		ted no she was not					
	ready to get up	yet.					
	Intonious with	CNA #2 on 2-13-12 at					
	· ·	cated she cleans					
		ures daily. CNA #2					
		dent #20 had not ate					
	,	/. CNA #2 indicated					
		w when resident's					
		d be soaked; she					
	_	g shift should take					
	·	ht and soak them.					
		ed Resident #20's					
		ot been cleaned today.					
		ed a lot of residents					
	1	neir dentures in when					
		in the morning. CNA					
		me residents sleep					
		ires in. CNA #2					
		cility did not have					
		the residents' dentures					
	l '	s' families had to					
	l ·	aning tablets for the					
		#2 indicated denture					
	· ·	changed every three					
		oservation with CNA #2					
	· ·	ere were three boxes of					
	_	cterial with baking					
		ent single tablet boxes					
		per box in the storage					
	room. CNA #2	stated " I guess we do					
	-						

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Event ID: QZDZ11

Facility ID: 000080

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155160	B. WIN			02/14/	2012
NAME OF B	DROVIDED OD GUDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIEF	C		990 N 1	6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	have them."						
		ident #20's Medication					
		Record (MAR) on					
		a.m., indicated the					
	resident was to	have her dentures out					
	of her mouth u	nless she was eating.					
	Interview with (CNA #2 on 2-13-12 at					
	9:40 a.m., indic	cated the information					
	· ·	t #20's dentures not					
		outh should have been					
		signment sheet.					
		CNA assignment sheet					
		id not indicate any					
		out the resident not					
	_	tures in except when					
		J. CNA #2 indicated					
		ow how information like					
	that was suppo						
		to the CNAs. CNA #2					
		lid not know Resident					
	#20 had false t	eetn.					
	Interview with I	LPN #5 on 2-13-12 at					
	9:53 a.m., indic	cated the reason					
	·	vas not have dentures					
		eating was because					
		nouth got sore easy					
	and she had th						
		s also to ensure the					
		ures were cleaned.					
		ed a copy of the CNA					
	I	eet and there was no					
	_	for Resident #20 to					
	documentation	IUI RESIDEIIL #20 LO					

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Event ID: QZDZ11

Facility ID: 000080

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE COMP	
		155160	B. WING			02/14	/2012
	PROVIDER OR SUPPLIER	TATION CENTRE & SUITES		990 N 1	DDRESS, CITY, STATE, ZIP COL 6TH ST ASTLE, IN 47362	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	Review of the ron 2-13-12 at 9 resident's diagrater were not limited Obstructive Pul (COPD), arthritanxiety, depression failure, Urinary difficulty voiding induced hypergagar). The Minimum I assessment for 1-17-12, indica cognitive status 15- cognitively hygiene (includ was extensive aperson. The care plan for 1-17-12, indicatrisk for unintentials	Imonary Disease is, osteoarthritis, ision, congestive heart Tract Infection (UTI), g and history of steroid glycemia (high blood Data Set (MDS) Resident #20 dated ted the following: s summary score was intact and personal ing brushing teeth) assistance of one or Resident #20 dated ted the resident was at tional weight loss					
	meals and diag depression. Th indicate any ap interventions re sore mouth and	tal discharge note for					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155160	A. BUILDING	00	COMPLETED 02/14/2012
		155100	B. WING	A DDDDGG GUTTY GT - T-	02/14/2012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE 16TH ST	
	ROOKE REHABILI	TATION CENTRE & SUITES		CASTLE, IN 47362	_
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
TAG		*	TAG	BELLELENCTY	DATE
		esident complained of buth, this was most			
		y to the steroids she			
	1	as started on Mary's			
		ash (treatment for oral			
	1	nl pain) and that			
		her. The resident was			
		ed back to the facility			
	with a prescript	•			
	The discharge	medication list from			
	the local hospit	al for Resident #20			
	dated 1-10-12,	indicated the resident			
	was ordered M	ary's magic			
		nilliliters every six			
		last dose was given on			
	1-10-12 at 10:0	00 a.m.			
	The facility's ph	nysician orders for			
	Resident #20 d	lated 1-10-12,			
		der for Mary's magic			
		ne orders were signed			
		e physician orders			
	were not signed	d by the physician.			
	The progress n	ote for Resident #20			
		at 3:45 p.m., indicated			
		ad returned from the			
	hospital. The d	octor orders were			
		pital and faxed to the			
	pharmacy and	the doctor.			
	The progress n	ote for Resident #20			
		at 6:39 p.m., indicated			
		nouth was sore again.			

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Facility ID: 000080

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155160	B. WIN			02/14/	2012
NAME OF P	PROVIDER OR SUPPLIEF	8		990 N 1	ADDRESS, CITY, STATE, ZIP CODE		
	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	This was report without getting what to do. The progress or dated 1-25-12 a call was place. The resident's resident to have mouthwash. The notified that the	ted to the doctor an answer back about note for Resident #20 at 7:11 p.m., indicated ed to resident's family. family requested the e Mary's magic ne family member was e physician was out of here would be a follow		TAG	DEFICIENCY)		DATE
	up in the morning The fax sent to Resident #20 conducted complained of mouth. The resident May we have a response was, times a day for The progress redated, 1-26-12 the received armagic mouthwood and for 10 days Review of the I	the physician for lated 1-26-12 at 7:50 the resident a sore throat and sident's family was ry's magic mouthwash. In order? The physician ok one teaspoon four 10 days. Interest of the physician					
	indicated the re first dose of Ma	through 1-31-12, esident received her ary's magic mouthwash 1-27-12 at 6:00 a.m.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI		
AND PLAN	OF CORRECTION	155160	- 1	LDING	00	02/14/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	₹			6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		the resident went 17		mo			BATE
		eatment for oral sores					
	1	f discharge from the					
	local hospital c	on 1-10-12.					
	 .						
	The weights fo						
		0-1-11, the resident					
		ounds, and on 2-13-12 eighed 107 pounds.					
	the resident we	signed for poditido.					
	The ER (Emer	gency Room) record					
	for Resident #2	20 dated 2-8-12,					
		esident had a syncope					
	l '	after choking on a					
		resident stated she felt					
	1	e resident had weight eral months and was					
		ent had a decrease in					
		severe episode of					
	thrush.	•					
		order for Resident #20					
		t 12:00 p.m. indicated					
	the resident wa	en eating until mouth					
	heals.	en eating until mouth					
	During observa	ation and interview with					
		on 2-13-12 at 12:48					
	' '	ent ate about 25 % of					
		indicated everything					
	taste bland.						
	During observa	ation on 2-14-12 at					
		N #1 was passing					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	
		155160	B. WI	NG		02/14/	2012
NAME OF F	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
				990 N 1			
STONEB	ROOKE REHABIL	ITATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Resident #20. LPN #1					
	•	the resident her Mary's					
	•	ash. Resident #20					
		ne LPN to wait because					
		e her dentures out so					
	1	the mouthwash on her					
	•	nt #20 indicated to LPN res on the left upper					
		ns. The resident pulled					
	_	and showed the LPN #1					
		eft upper part of her					
	mouth.	or apper part of her					
	modin.						
	Interview with	RN #10 on 2-14-12 at					
		dicated the procedure					
		ident returned from the					
	hospital, was t						
	-	ders were usually faxed					
		n or the physician was					
		list of discharge					
	medications.	RN #10 indicated the					
	physician had	not signed the					
	1	ers for Resident #20's					
	medication on	1-10-12.					
	3.1-46(a)(1)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETE B. WING 02/14/201			ETED		
		100100	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/14//	2012
NAME OF PR	ROVIDER OR SUPPLIER				6TH ST		
STONEBR	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
	483.25(k) TREATMENT/CA The facility must receive proper tre following special Injections; Parenteral and e Colostomy, urete Tracheostomy car Tracheal suction Respiratory care Foot care; and Prostheses. Based on obse record review, to provide a reside resulting in red, long thick toen sampled for foot sample of 15 (F Finding include 1.) Interview w and Family men #20 on 2-9-12 a the resident's fe member #2 ind corns on her fe to go buy the co put on the reside members indica not taking care Interview with F 2-13-12 at 9:06	nteral fluids; erostomy, or ileostomy care; are; ing; ; rvation, interview and the facility failed to ent with foot care, , dry painful feet with ails, for 1 of 1 resident of care in a stage two Resident #20).	F03	TAG 28	F-328 Treatment /Care For Special Needs1) What correct action(s) will be accomplished those residents found to have been affected by the deficient practice: Resident #20 has be seen by podiatrist on 2/14/12.2 How other residents having the potential to be affected by the same deficient practice will be identified and what correctice action(s) will be taken: All residents have the potential to affected by the alleged deficient practice. The nursing staff will re-educated by DNS/designee (3/6/12) on nail care and podiate service/referal. Nail care will be completed weekly with shower and as needed. Licensed nurs will notify social services of residents identified in need of podiatry services. Social Servito schedule podiatry services fafternoon visits to accomodate residents / staff to assist if resident declines. All residents with a signed consent will be set by podiatry quarterly.3) What	tive for sen 2) be nt be stry se se ce for all	DATE 03/15/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		155160				02/14/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
OTONED		TATION OF NITE A OUTTO			6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		re l	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	she had been v	wearing slippers due to			measures will be put into place		
		made her feet hurt			what systemic changes will be		
	more.				made to ensure that the deficie	ent	
	111010.				practice does not recur: The		
	Duning a sharen a	-ti 0 10 10 -t			nursing staff will be re-educate		
	_	ation on 2-13-12 at			by DNS/designee (3/6/12) on r		
	· ·	IA #5 took off Resident			care and podiatry service/refered	al.	
	#20's socks. Th	ne resident's feet were			weekly with showers and as		
	dry, the toenail	s were long and thick,			needed. Licensed nurse will		
	there was a red	d knot on her left foot			notify social services of reside	nts	
	and on the sec	ond toe on the right			identifed in need of podiatry		
		ndicated the resident's			services. Social Services to		
		ter today than they did			schedule podiatry services for		
		iter today triair triey did			afternoon visits to accomodate	all	
	last week.				residents / staff to assist if		
					resident declines. ADNS/SDC		
	Review of the r	record of Resident #20			visual assessment monthly of		
	on 2-13-12 at 9	9:54 a.m., indicated the			residents for appropriate nail of	are	
	resident's diag	noses included, but			during monthly skin		
	were not limite				assessment.4) How the		
		Imonary Disease			corrective action(s) will be monitored to ensure the deficie	ont	
		tis, osteoarthritis,			practice will not recur: The CQ		
	l ` ′				audit tool for Accomodation of		
		ssion, congestive heart			Needs will be utilized to daily		
		Tract Infection (UTI),			weeks, bi-weekly times 2 mon		
	difficulty voidin	g and history of steroid			and monthly x 3 months and for	or 3	
	induced hyperg	glycemia (high blood			quarters thereafter for resident	S	
	sugar).				receiving podiatry		
					services. Finding from CQI		
	The Minimum I	Data Set (MDS)			process will be revieed monthl	у	
		r Resident #20 dated			and an action plan will be		
		ited the following:			implemented for threshold below 95%. Shower sheets will be)VV	
	•	•			reviewed daily x 2 weeks,		
		s summary score was			bi-weekly x 2 months, and		
		intact, bed mobility-			monthly x 3 months and quarte	erlv	
		stance of one person,			thereafter for completion of na		
	transfer- extens	sive assistance of two			care.Results will be reviewed		
	people, walk in	room- did not occur.			monthly with IDT.5) By what o	late	
	, ,				the systemic changes will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	A. BUILDING 00			COMPLETED	
		155160	B. WIN			02/14/	2012	
	.novnnn				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEI	K			6TH ST			
		ITATION CENTRE & SUITES		NEW C	ASTLE, IN 47362			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE	
		rogress note for			complete: The corrective acti will be completed on or before			
	· ·	dated 10-24-11,			3/15/12.	-		
	indicated the re							
		(fungal infection on the						
	l '	lent had a keratoma						
		six or more toenails						
	debrided.							
	The podiatry of	rogress note for						
		rogress note for dated 1-4-12 indicated						
		as sleeping and woke						
	up and stated '	"quit it."						
	Interview with t	the Director Of Nursing						
	(DON) on 2-13	s-12 at 11:30 a.m.,						
	indicated Resid	dent #20 refused to see						
		n 1-4-12. When						
	· •	esident was asleep						
	· ·	considered a refusal,						
		ated the resident was						
		ee the podiatrist this						
	month.	and beginning and						
	The Social Ser	vice Director (S.S.D.)						
	on 2-13-12 at 1	11:39 a.m., indicated						
	the podiatrist u	sually sees residents						
	· •	onths. The S.S.D.						
	1	dent #20 was on the						
		be seen on 2-29-12.						
	'	icated the last date of						
	service for Res							
	10-24-11.							
	.0 2							
	Interview with	the S.S.D. on 2-13-12						
	at 11:45 a.m. ii	ndicated she talked						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155160	A. BUILDING B. WING	00	COMPLETED 02/14/2012			
	PROVIDER OR SUPPLIER BROOKE REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	with the podiatrist today and he was going to come in and see Resident #20 today. The S.S.D. indicated the podiatrist who was going to see the resident was not the facility's regular podiatrist, but was a part of a group of the regular podiatrist. The S.S.D. indicated the podiatrist was going to start coming in the afternoon to see Resident #20 and also going to have him come get her before he goes and sees the resident. 3.1-47(a)(7)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUC			E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155160	B. WING		02/14/2012
			_	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R	990	N 16TH ST	
STONEB	ROOKE REHABIL	ITATION CENTRE & SUITES		V CASTLE, IN 47362	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0329 SS=D	UNNECESSAR Each resident's from unnecessa drug is any drug dose (including excessive durat monitoring; or w for its use; or in consequences w should be reduc combinations of Based on a con resident, the fac residents who h drugs are not gi antipsychotic dr treat a specific of documented in residents who u receive gradual behavioral inter contraindicated these drugs. Based on reco interview, the fac adequately mo of a medicatio orders to obtain	drug regimen must be free ary drugs. An unnecessary when used in excessive duplicate therapy); or for ion; or without adequate without adequate indications the presence of adverse which indicate the dose and discontinued; or any if the reasons above. In prehensive assessment of a collity must ensure that ave not used antipsychotic ven these drugs unless ug therapy is necessary to condition as diagnosed and the clinical record; and se antipsychotic drugs dose reductions, and ventions, unless clinically, in an effort to discontinue	F0329	F-329 Drug Regimen Is Free From Unnecessary Drugs1) What corrective action(s) will accomplished for those reside found to have been affected by the deficient practice: Reside #58 blood pressure and pulse	be ents by ent
		ation, for 1 of 10 ewed for medications. 3)		be documented prior to administration of cardizem, be on physician order and notifyi physician if holding greater to	ng
	Findings include	de:		days.2)How other residents having the potential to be affe by the same deficient practice	e will
	On 2/08/12 at	12:30 p.m., review of		be identified and what correct action(s) will be taken: All	ive

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155160	B. WIN	G		02/14/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C .		990 N 1	6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident # 58's	s Physician rewrites,			residents have the potential to		
	dated 2/1/12 to	2/29/12, indicated			affected by the alleged deficien		
	Cardizem 60 m	ng every 6 hours, blood			practice. Licensed nurses will re-educated by	be	
	pressure and h	eart rate, hold if			DNS/designee (3/6/12) on		
	systolic less th	an 90 or heart rate less			physician orders and obtaining	1	
	than 55.				vital signs per order prior to	,	
					medication administration. All		
	Review of the I	Medication			residents on medication		
		Records, dated			requiring vital signs have been	1	
		h 12/21/11 and 1/1/12			identified. Vital signs will be placed in MAR prior to medica	tion	
	_				administration based on physic		
	_	2, indicated the blood			orders and notifying physician		
	•	neart rate were not			holding for 3 days.3) What		
	obtained 15 tin				measures will be put into place	e or	
	administration				what systemic changes will be		
	December and	6 times in January.			made to ensure that the deficie		
					practice does not recur: Licen	sed	
	Interview with t	the ADON on 2/9/12 at			nurses will be re-educated by DNS/designee (3/6/12) on		
	1:10 p.m. indic	ated she could find no			physician orders and		
	other documer	tation that Resident #			obtaining vital signs per order		
	58's blood pres	ssure and pulse had			prior to medication		
	•	on the missing dates in			administration. All residents o	n	
	December and	•			medication requiring vital signs	3	
	December and	barraary.			prior to medication have been		
	3.1-48(a)(3)				identifed, monitoring per		
	0.1 -4 0(a)(3)				administrative nursing. Vital signs will be placed in MAR pr	ior	
					to medication administration,	101	
					monitoring per administrative		
					nursing.4) How the corrective		
					action(s) will be monitored to		
					ensure the deficient practice w		
					not recur: Administrative nursi	•	
					to audit daily, 5 days a week, weeks, biweekly x 2 months a		
					monthly thereafter. Re-educate		
					when appropriate and follow u		
					with disciplinary action as	•	
					necessary.5) By what date the	Э	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155160	(X2) MULTIPLE CON A. BUILDING B. WING	00	(x3) DATE SURVEY COMPLETED 02/14/2012
NAME OF PROVIDER OR SUPPLIER STONEBROOKE REHABILITATION CENTRE & SUITES	990 N 16	DDRESS, CITY, STATE, ZIP CODE STH ST ASTLE, IN 47362	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
		systemic changes will be complete: The corrective action will be completed on or before 3/15/12.	ons

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